

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

04-13

2. STATE

MO

3. PROGRAM IDENTIFICATION: TITLE XIX OF
THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

OCTOBER 1, 2004

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447-332(a)(b)

7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$ _____
b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

4.19-B page 3c

9. PAGE NUMBER OF THE SUPERSEDES PLAN
SECTION OR ATTACHMENT (If Applicable):

4.19-B page 3c

10. SUBJECT OF AMENDMENT:

Annual assurance of the pharmacy program adherence to the requirements of federal regulation.

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT *u*
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPE NAME:

Steven E. Renne

14. TITLE:

Acting Director, Department of Social Services

15. DATE SUBMITTED:

December 14, 2004

16. RETURN TO:

Division of Medical Services
Post Office Box 6500
Jefferson City, MO 65102-6500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

December 15, 2004

PLAN APPROVED - ONE COPY ATTACHED

18. DATE APPROVED:

February 11, 2005

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

James G. Scott

22. TITLE

Acting Associate Regional Administrator
for Medicaid and Children's Health

23. REMARKS:

State: Missouri

The annual assurance is given that, for the period October 1, 2003, through September 30, 2004, the requirements of State Medicaid Manual 6305.1.A and 6305.2 are met. In the aggregate, Missouri's Medicaid expenditures for multiple source drugs identified and listed in accordance with 42 CFR 447.332(a) are in accordance with the upper limits specified in 42 CFR 447.332(b).

State Plan TN# 04-13
Supersedes TN# 03-21

Effective Date October 1, 2004
Approval Date FEB 11 2005